



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FONDREN ORTHOPEDIC GP LLP
7401 SOUTH MAIN STREET
HOUSTON TEXAS 77030

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

SEABRIGHT INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-13-1565-01

MFDR Date Received

February 21, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was denied as documentation was not received. I have attached a documentation to support all services billed along with a copy of EOB and claim form for your review. We respectfully ask that this claim be reprocessed for payment."

Amount in Dispute: \$113.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response to the DWC060 request. A copy of the DWC060 was placed in the carrier representative box 19 on February 28, 2013, assigned to Flahive Ogden & Latson. The DWC060 was stamped received by FOL Fileroom, Gordon Clayton on March 1, 2013. A decision will therefore be issued based on the information available in the dispute at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 2012	99213	\$113.86	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline reimbursement for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 401 – Workers' Compensation no-subscriber. Adjustment
- 740 – Per adjuster deny lack of documentation (medical report, operative report and or chart notes)

- 890 – Reprice according to adjuster instruction

Issues

1. Did the requestor submit documentation to support the level of service billed?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203 “(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”
 - The definition of CPT code 99213 is “Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
 - Review of the submitted documentation which consisted of a one page document identified as “Page 2”, dated June 13, 2012, does not meet the minimum documentation requirements for billing CPT code 99213, as a result reimbursement cannot be recommended.
2. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for CPT code 99213.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	July 31, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.